Speaking up in resource-constrained settings: how to secure safe surgical care in the moment and in the future?

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The provision of safe surgical care in low- and middle-income countries is challenging. Mortality and morbidity in the perioperative period are high, and likely to rise as the burden of non-communicable diseases increases in these countries.[1] Both access to, and quality of, surgical and perioperative care remain challenging in much of the world. In many African countries, for example, risk of mortality following surgery is around twice the global average, despite more favourable patient risk profiles in terms of age and acuity of condition.[2] Resource deficiencies appear to be heavily implicated in these poorer outcomes, especially during post-operative care, and for patients who would benefit from care and surveillance in intensive care facilities, which are scarce in low-income settings.[3] However, as Mawuena and Mannion show in an article in this issue,[4] resource limitations can have important impacts beyond their direct effect on what is available before, during and after surgery: they can also contribute to an environment in which identifying, learning from, and acting on concerns about quality of care become especially difficult.

Reporting on a study undertaken in two Ghanaian hospitals, the authors identify ways in which resource constraints—including both material deficiencies and staff shortages that lead to excessive workloads—militate against the voicing of concerns. A key finding is that participants are typically reluctant to devote personal resources to speaking up that might at best seem futile, and at worst risk inviting opprobrium and further burdens for the speaker. Such reluctance is, of course, not unique to low-income settings. Silence about concerns is a problem well documented across the world, in healthcare and in other environments,[5,6] and many of the reasons are very similar to those found by Mawuena and Mannion: uncertainty about the benefits likely to arise from raising concerns; fear about the responses of superordinates; and the risk of adverse consequences for relationships with peers.[5,7,8] Failures on the part of organisations and managers to listen effectively are also familiar from other settings, and act to further suppress voice.[9] The scale and scope of the constraints facing participants, however, and the risks they pose to the safety of patients and staff alike, are likely well outside the experience of practitioners in most high-income surgical settings. Similarly, Mawuena and Mannion's findings, like those of others,[10] suggest that steep authority gradients and strongly hierarchical relationships between professional groups may pose a particular challenge in resource-constrained contexts.

The paper highlights an important tension faced by practitioners in the hospitals studied: between addressing the immediate needs of the patient in front of them using whatever resources may be available (safety 'in the moment'), and ensuring quality and safety of care for the future patient population (safety 'in the future'). Mawuena and Mannion document the improvisations made by doctors and nurses to secure the safety of patients in the moment, which, in the absence of appropriate resources, meant compromises, shortcuts and quick fixes. The participants understood all too well that the solutions they had found were far from satisfactory, but felt they had little other choice.

While improvisation of this kind may sometimes be a necessity, the problem is that it can very quickly become routine: a matter of normalised deviance and accepted standard.[11,12] Acquiescing to substandard care also creates dilemmas for individual practitioners, who may find themselves caught in "bonds of transgression […] shared by providers as a way of getting things done."[13] This may provoke responses that further subdue voice. What is so bad about this particular deviation, when you seemed happy to tolerate (or perhaps even initiated) something similar last week? Why cause trouble for your colleagues who, like you, are probably just competent, well meaning individuals trying to do the best job they can for their patients in difficult circumstances?

An important question, therefore, is what can be done to reconcile these conflicting priorities: to create environments and cultures that permit practitioners to do the best they can for patients in need of care right now, while still upholding the highest standards and aspirations for quality that staff and patients both deserve. Research informed by the Safety II perspective shows that good healthcare practice is not always a matter of adhering to the standards set out in "work as imagined"—and indeed that sometimes, the improvisations of "work as done" are key to the delivery of safe care.[14] This research, however, has predominantly taken place in high-income settings,[15] where the day-to-day workarounds

are perhaps lower-stakes than, for example, squeezing blood from gauzes before reusing them.[4]

How, then, might healthcare providers organise to achieve the right balance between getting the job done and securing the longer-term safety of patients and staff? Undoubtedly, acknowledgement of the necessary evil of occasional compromises will form a part of this, as will mature dialogue oriented towards shared principles across the range of groups affected. There is a need to reach common ground about what can reasonably be tolerated in what circumstances, and what constitutes cause for any practitioner involved to 'stop the line',[16] in relation to safety, quality and interpersonal behaviour. Concepts such as 'just culture' might offer a model for ensuring that expectations, responsibilities and accountability for acts are distributed and enacted fairly, in a way that acknowledges the constraints and demands faced by practitioners.[17] Of course, putting such ideas into practice is no small task, and requires not just agreement on the principles but also work to change culture and establish and embed institutions for realising them.

Even then, however, there is a risk of 'safety imperialism': exporting solutions developed and tested in high-income contexts on the assumption that these offer the best model for every setting. As Kimball and Wagenaar highlight, low- and middle-income countries may have features that necessitate the adaptation of interventions that have worked in high-income settings,[18] and others have similarly urged caution with regard to unreflexive transfer of the products of the healthcare industry of the high-income world.[19,20] Comparative analyses highlight the contingency of good professional practice not only on material resources, but on wider cultural norms, legal systems and social institutions.[21]

More than this, though, it is important to resist the homogenising tendency of terms like 'low- and middle-income country', and recognise the diversity of resource levels, organisational forms and socio-cultural contexts both between and within countries covered by this broad umbrella. There is no more reason to believe that the challenges facing healthcare practitioners in Ghana mirror those in Laos than that the problems of the United Kingdom's health system are reducible to those of the United States. Similarly, it should come as no surprise that some healthcare organisations in a low- or middle-income country perform better than others, as shown by recent work seeking to improve surgical quality in Tanzania.[22]

Thus, while certain universal principles regarding justice, responsibility and accountability may apply globally, operationalising and institutionalising them in a sustainable way demands local ownership, and sensitivity to the consequences of national, regional and even local context. The benefits of nurturing, listening to and learning from more diverse sources of insight about how to do improvement are potentially great. Ultimately, innovative approaches to valuing voice developed outside the high-income centres that have traditionally dominated thinking could have important value worldwide.[23]

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